

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04440

04436

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| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN lb 1mo.13days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | d. STREET ADDRESS 913 S. Washington e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ROY | | 4. DATE OF DEATH Month April Day 26 Year 1962 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-24-21 | |
| 9. AGE (In years last birthday) 40 yrs. | | 10. IF UNDER 1 YEAR Months 40 Days 0 | |
| 11. IF UNDER 24 HRS. Hours 0 Min. 0 | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Fiber Glass Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Lonnie G. Bailey (deceased) | | 14. MOTHER'S MAIDEN NAME Minnie Murphy (deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-II | | 16. SOCIAL SECURITY NO. 241-22-6347 | |
| 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis and Bronchopneumonia 540.0 DUE TO Combined effects of: (b) (a) Sub-total gastrectomy (4-24-62) for gastric ulcer. (c) (b) Chronic ascites, peritoneal reaction, and early cirrhosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease. | | INTERVAL BETWEEN ONSET AND DEATH 24-36 Hrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that Dr. A. L. Mooney attended the deceased from March 13, 1962 , to April 26, 1962 , and that death occurred at 6:54 a.m. from the causes and on the date stated above. | | 22a. SIGNATURE A. L. Mooney M.D. 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. | |
| 22b. DATE SIGNED 4-27-62 | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 4/30/62 | | 23b. DATE THEREOF 4/30/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City, town or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md. | | 25a. REC'D BY REGISTRAR MAY 3 1962 DATE 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

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April 26

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Machine Operator

1st. Class 2d.

North Carolina

Donnie G. Miller (deceased) 1st. Class 2d. (deceased)

Yes

241-2-877

Hospital Records, VA, Army Joint, MA.

Examination and Grossophrenia

Examination at:

(a) and local pathology (1-1-42) for

Micro.

(b) Chronic infection, infectious reaction, and early

Microscopic heart disease.

March 17, 1941

0:00 a.m.

4-17-41

Handwritten signature

1st. Class 2d. Clinical Records, VA, Army Joint, MA.

1st. Class 2d. Clinical Records, VA, Army Joint, MA.

1st. Class 2d. Clinical Records, VA, Army Joint, MA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G312 5/11/62 mh

CERTIFICATE OF DEATH

Reg. Dist. No.

04437

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 2 wks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Gertrude Middle Kirk Last Brown | | 4. DATE OF DEATH Month April Day 24 Year 1962 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 24, 1877 |
| 9. AGE (In years last birthday) 85 yrs. | | 10. IF UNDER 1 YEAR Months 2 Days 3 | |
| 11. IF UNDER 24 HRS. Hours 1 Min. 0 | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William B. Kirk | | 14. MOTHER'S MAIDEN NAME Lillis A. Ewing | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. No | |
| 17. INFORMANT Walter E. Brown | | Address Newark, Del. 1982 Nottingham Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Unk | | INTERVAL BETWEEN ONSET AND DEATH 12 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-13 , 1962, to 4-23 , 1962, that I last saw the deceased alive on 4-23 , 1962, and that death occurred at 1:15 PM , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE Williford Eppes | | M.D. 327 East Main Street | |
| PHYSICIAN'S NAME (Type) Williford Eppes, M.D. | | Newark Delaware | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF April 27, 1962 | 22c. NAME OF CEMETERY OR CREMATORY Sharps C.m. | 22d. LOCATION (City, town, or county) (State) Fair Hill, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE R.T. Jones | | ADDRESS Newark, Del. | |
| 24a. REC'D BY REGISTRAR DATE APR 30 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |

VS. A1SME
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MEDICAL CERTIFICATION

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MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04440

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|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton | | c. LENGTH OF STAY IN 1b 1 1/2 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 2618 | | | | d. STREET ADDRESS R. D. #3, Box 2618 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CORA BELL CHURCH | | | | 4. DATE OF DEATH April 25, 1962 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 14, 1896 | |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY General | | 11. BIRTHPLACE (State or foreign country) Ash County N. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Pilkenton | | | | 14. MOTHER'S MAIDEN NAME Rizzie Ellen | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. no | | | |
| 17. INFORMANT Mr. Ray Church R.D. #3, Elkton, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 mins. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED R. C. DODSON, M.D. Rizzie Sun, Md. April 25, 1962 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 28, 62 | | 22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery | | 22d. LOCATION (City, town, or country) (State) Elkton, Md. | |
| 23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME Small & Dee Elkton, Md. | | | | 24a. REC'D BY REGISTRAR DATE APR 27 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Huns | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04444

04441

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Elkton</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> <u>HENRY</u> <u>CROSS</u> | | | 4. DATE OF DEATH Month <u>23</u> , Day <u>17</u> , Year <u>1962</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH <u>June 12, 1888</u> | | 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR: Months <u>1</u> Days <u>17</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>17</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Nr. Middletown, Del.</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Jack Cross</u> | | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Idel Rebecca</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service) | | | | | |
| 16. SOCIAL SECURITY NO. <u>212-16-8078</u> | | 17. INFORMANT <u>Mrs. Sophie Ann Lotman, Elkton, Md.</u> Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Bronchopneumonia, bilateral, diffuse</u> 162.1 } DUE TO <u>Bronchogenic carcinoma with metastases to hilar nodes and erosion of the spine</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>unknown</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Coronary arteriosclerosis</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>1</u> p.m. <u>15</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) <u>Elkton</u> (County) <u>Cecil</u> (State) <u>Md.</u> | | 21. I certify that (I) (this hospital) attended the deceased from <u>April 19, 1962</u> , to <u>Apr. 23, 1962</u> that (I) (we) last saw the deceased alive on <u>April 23, 1962</u> , and that death occurred at <u>1:15pm</u> from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>4/24/62</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u> | | 22d. ADDRESS <u>233 E. Main Street, Elkton, Maryland</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>April, 27, 62</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Cem.</u> | | | |
| 23d. LOCATION (City, town or county) <u>Elk Neck, Md.</u> (State) | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>Elkton, Md.</u> | | | | | |
| 25a. REC'D BY REGISTRAR <u>APR 27 '62</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hance</u> | | | | | |

1 FOR STATE HEALTH DEP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04445

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04442

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil Ct. Elkton MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Elkton, Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton, Md. | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Elkton, Maryland | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Jessie England | | 4. DATE OF DEATH April 10, 1962 | | 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/25/1891 | | 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Phillipsburg, Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Harry C. Thompson | | | | 14. MOTHER'S MAIDEN NAME Alva I Sponagle | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Funeral Director Coffman | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Failure 7824 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE R.C. DODSON M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) R.C. DODSON, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Rising Sun, Maryland | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 4-13-62 | | 22c. NAME OF CEMETERY OR CREMATORY Rosebank Cemetery | |
| 23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME Donald M. Zee | | | | 22d. LOCATION (City, town, or country) Calvert, Maryland | | (State) | |
| 24a. REC'D BY REGISTRAR APR 16 '62 | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Evans | | | |

MEDICAL CERTIFICATION

01113

WILSON, FRANKLIN - ASSISTANT OF BRUSH

35230

1930

[Faint, mostly illegible text covering the middle section of the page, possibly a list or report.]

R. C. DODGE, M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 1yr. 3mo. 14days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2811 Cathedral Avenue, N.W. d. STREET ADDRESS 2811 Cathedral Avenue, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES FREDERICK GEIGER | | 4. DATE OF DEATH Month April Day 11 Year 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-4-94 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR Months 11 Days 19 | 11. IF UNDER 24 HRS. Hours 62 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Henry Geiger (deceased) | |
| 14. MOTHER'S MAIDEN NAME Helen V. Hickey (deceased) | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | |
| 16. SOCIAL SECURITY NO. WW-I 341-05-5650 | | 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia, due to circulatory disturbance, 36-48 hrs 332X DUE TO left cortex, thrombosis middle cerebral artery Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, generalized cerebral severe unknown (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, severe | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | |
| (State) | | 21. I certify that XXXXXX attended the deceased from December 28 1960 , to April 11, 1962 and that death occurred at 5:25am M, from the causes and on the date stated above. | |
| 22a. SIGNATURE A. L. Mooney | | 22b. DATE 4-11-62 | |
| 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE THEREOF 4/13/62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington | | 23d. LOCATION (City, town or county) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md. | | 25a. REC'D BY REGISTRAR APR 13 '62 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna | | 25c. DATE | |

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Journal of Management Education 30(6)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO A LOCAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon-paper pages 3 and 4 and file them with the State Dept. of Health.

VR A15 (4)
ISM 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH e. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY Virginia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Norfolk d. STREET ADDRESS 238 W. 26th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) GEORGE W. GOFF | | | 4. DATE OF DEATH Month April Day 2 Year 19 62 | | | 5. SEX Male | | | 6. COLOR OR RACE White | | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH 12-23-93 | | | 9. AGE (In years last birthday) 68 yrs. | | | IF UNDER 1 YEAR Months 8 Days 3 | | IF UNDER 24 HRS. Hours 3 Min. 3 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Various-kinds | | | | 11. BIRTHPLACE (County & State, or foreign country) Virginia | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Perry Goff (deceased) | | | | | | 14. MOTHER'S MAIDEN NAME Elvira (?) Goff | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. WW I | | | | 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis generalized | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY Hour VA e.m. 19 p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that XXXXXX attended the deceased from 12-3 , 19 33 to April 2 , 19 62 and that death occurred at 6:00 pm from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE A. L. MOONEY | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED 4-3-62 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY | | | | | | 22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | | | 23b. DATE THEREOF 4/4/62 | | | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | | 23d. LOCATION (City, town or county) (State) Arlington, Va. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son | | | | | | ADDRESS Havre de Grace, Md. | | | 25a. REC'D BY REGISTRAR APR 5 '62 | | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kinn | | |

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

04448

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04445

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|--|--|---|---|---|--|------------------------------|---------|
| 1. PLACE OF DEATH a. COUNTY | Cecil | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE | Maryland | b. COUNTY | Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | Perry Point, | c. LENGTH OF STAY IN lb | Less than 24 hours | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | Havre de Grace | 1224-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | Veterans Administration Hospital | d. STREET ADDRESS | 608 Franklin | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First | Middle | Last | 4. DATE OF DEATH | Month | Day | Year |
| LOUIS | J. | HAFFNER | April | 1 | 1962 | | |
| 5. SEX | Male | 6. COLOR OR RACE | White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 7-16-97 |
| 9. AGE (In years last birthday) | 64 | IF UNDER 1 YEAR | Months | Days | Hours | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Foreman | 10b. KIND OF BUSINESS OR INDUSTRY | Spray Paint | 11. BIRTHPLACE (State or foreign country) | Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? | USA |
| 13. FATHER'S NAME | Louis G. Haffner (deceased) | 14. MOTHER'S MAIDEN NAME | Chrisinthis Madel (deceased) | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/branches of service) | Yes | 16. SOCIAL SECURITY NO. | Not available | 17. INFORMANT | Hospital Records, VAH, Perry Point, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, retroperitoneal, massive | DUE TO | (b) Rupture of aorta, due to arteriosclerosis. | 10-12 hours | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | (c) Arteriosclerosis, generalized, severe. | Unknown | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | Cirrhosis of the liver. | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY | Month, Day, Year | 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| Hour a.m. p.m. | 19 | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: | Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE | R. C. DODSON | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | DATE SIGNED | 4-2-62 | |
| EXAMINER'S NAME (Type) | R. C. DODSON | Address (Street, city, town, or county) | Rising Sun, Md. | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or country) | (State) | | | |
| BURIAL | Apr. 4, 1962 | Rock Run CEM. | Havre de Grace, Md. | | | | |
| 23. FUNERAL DIRECTOR | ADDRESS | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE | | | | |
| R. Madison Mitchell, Havre de Grace, Md. | | DATE APR 6 '62 | Anthony S. Thomas | | | | |

VR A15ME
5M 1/62

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04449

CERTIFICATE OF DEATH

04446

| | | | |
|--|---------------------------|--|------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Pennsylvania b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | d. STREET ADDRESS 6136 Wayne Avenue | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GEORGE M. HARRINGTON | | 4. DATE OF DEATH Month Day Year April 24 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-20-91 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney | |
| 11. BIRTHPLACE (County & State, or foreign country) Nebraska | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Michael Harrington | | 14. MOTHER'S MAIDEN NAME Margaret G. McHenry | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-I | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction acute 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20a. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20d. (City or town) (County) (State) | |
| 21. I certify that Dr. L. L. Moore attended the deceased from August 2, 1948, to April 24, 1962 and that death occurred at 3:10 am, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE A. L. Mooney | | 22b. DATE SIGNED 4-24-62 | |
| 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY | | 22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE THEREOF 4/26/1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington | | 23d. LOCATION (City, town or county) (State) Arlington, Va. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Pennington + Son | | 25a. REC'D BY REGISTRAR DATE MAY 3 '62 | |
| 25b. REGISTRAR'S SIGNATURE Curtis S. House | | | |



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CERTIFICATE OF DEATH

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| 1. PLACE OF DEATH a. COUNTY Cecil | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Md. | | | | c. LENGTH OF STAY in 1b 3 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Harry H. HIPKINS | | 4. DATE OF DEATH Month Day Year April 25, 19 62 | | 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-7-86 | | 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days | |
| 11. BIRTHPLACE (County & State, or foreign country) Havre de Grace, Md. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13. FATHER'S NAME George L. Hipkins | | 14. MOTHER'S MAIDEN NAME Amelia R. Oals | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. 243-38-8125 Unknown | | 17. INFORMANT VA Hospital Records - Perry Point, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 | | b. Myocardial infarction | | c. Arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 72 hours | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | DUE TO (b) | | DUE TO (c) | | unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that Dr. L. L. Moore attended the deceased from April 22, 1962, to April 25, 1962, that (s) (he) last saw the deceased alive on April 22, 1962, and that death occurred at 2:00 P.M. from the causes and on the date stated above. | | 22a. SIGNATURE A. L. MOONEY | | 22b. DATE SIGNED 4-25-62 | | 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE THEREOF April 28, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY Baker | | 23d. LOCATION (City, town or county) (State) Aberdeen, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster, Belair, Maryland | | 25a. REC'D BY REGISTRAR DATE APR 27 '62 | | 25b. REGISTRAR'S SIGNATURE C. L. Foster | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04451

CERTIFICATE OF DEATH

04449

Reg. Dist. No.

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|--|--|----------------------------------|--|---|--|--|--|---|--|--|--|---------------------------------------|--|---|--|
| 1. PLACE OF DEATH a. COUNTY CECIL | | | | 2. USUAL RESIDENCE (Where deceased lived. If residence before admission) a. STATE MARYLAND | | | | b. COUNTY CECIL | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTH EAST | | | | c. LENGTH OF STAY IN 1b 28 years | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTH EAST | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION - | | | | d. STREET ADDRESS - | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) BESSIE | | | | First M. | | Middle HOWARD | | Last HOWARD | | 4. DATE OF DEATH Month 4 | | Day 13 | | Year 1962 | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-25-1883 | | 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months 7 | | IF UNDER 24 HRS. Days 13 | | Hours 19 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY * | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | |
| 13. FATHER'S NAME DANIEL W. McVEY | | | | | | 14. MOTHER'S MAIDEN NAME MALINDA McDOWELL | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. none | | INFORMANT LOWELL C. HOWARD | | | | Address NORTH EAST, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis. DUE TO (c) Rheumatic Heart Disease. | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 Min. 1 Hour Years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, G.A.S. | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) CECIL | | (County) CECIL | | (State) Md | | | |
| 21. I certify that I attended the deceased from Feb. 15, 1962 , to Apr. 13, 1962 that I last saw the deceased alive on April 12, 1962 , and that death occurred at 12:05 A.M. ADDRESS (Street, city or town, state) Cecil Ave., North East, Maryland. DATE SIGNED April 14, 1962 | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Luis M. Caza | | | | M.D. Cecil Ave., North East, Maryland. | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) Luis M. Caza, M.D. | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 22b. DATE THEREOF 4-15-1962 | | 22c. NAME OF CEMETERY OR CREMATORY FRIENDS | | 22d. LOCATION (City, town, or county) CALBERT | | (State) CECIL Co., Md | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant | | | | ADDRESS North East, Maryland | | 24a. REC'D BY REGISTRAR APR 17 1962 | | 24b. REGISTRAR'S SIGNATURE John S. Kneas | | | | | | | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01110

CERTIFICATE OF DEATH

00151

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
BOSTON, MASS.

DATE OF DEATH: _____
PLACE OF DEATH: _____
AGE: _____
SEX: _____
RACE: _____
MARRIAGE: _____
OCCUPATION: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF DECEASED: _____
SIGNATURE OF WITNESSES: _____
SIGNATURE OF PHYSICIAN: _____
SIGNATURE OF REGISTRAR: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be refiled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04452

CERTIFICATE OF DEATH

Reg. Dist. No. 04450

| | | | |
|---|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Elkton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 170 E. Main Street | | d. STREET ADDRESS 170 E. Main Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First GROVER Middle C. LODGE Last | | 4. DATE OF DEATH Month Apr. 28, Year 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 19, 1884 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY General | |
| 11. BIRTHPLACE (State or foreign country) Nr. Elkton, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Richard Lodge | | 14. MOTHER'S MAIDEN NAME Jane | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 219-10-8713 | |
| 17. INFORMANT Mrs. Mary Ellen Lodge, Elkton, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1810 DUE TO Carcinoma of Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-25-1962, to 4-26-1962, that I lost sowl the deceased alive on 4-27-1962, and that death occurred at 9:15 P.M. from the causes ond on the dote stated above. ADDRESS (Street, city or town, state) DATE SIGNED April 30, 1962. | | | |
| ACTUAL SIGNATURE Jacob J. Greenwald M.D. | | | |
| PHYSICIAN'S NAME (Type) Jacob J. Greenwald M.D. Elkton, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 2, 1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk. | | 22d. LOCATION (City, town, or county) (State) Nr. Elkton, Md. | |
| 23. BURIAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald M. Ree Elkton, Md. | | 24a. REC'D BY REGISTRAR DATE MAY 2 '62 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

1941-40

CERTIFICATE OF DEATH

06-22

(M)

WILLIAM J. BROWN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04453

CERTIFICATE OF DEATH

04451

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|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville c. LENGTH OF STAY IN IT 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VAH., Perry Point, Md. | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, d. STREET ADDRESS 802 Erie Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) JOHN V. MARCUCCI | | | 4. DATE OF DEATH April 23 1962 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-11-20 | | 9. AGE (In years last birthday) 42 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | | 10b. KIND OF BUSINESS OR INDUSTRY private | | 11. BIRTHPLACE (County & State, or foreign country) Steubenville, Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? USA. | | | 13. FATHER'S NAME BIAGIO MARCUCCI | | |
| 14. MOTHER'S MAIDEN NAME CANARI CANDIDA | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII Unknown | | |
| 16. SOCIAL SECURITY NO. Unknown | | | 17. INFORMANT Hospital Records. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL BLEEDING 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) LAENNEC'S CIRRHOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 Days 1 year | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) 19 | | 20g. (County) 19 | | 20h. (State) 19 | |
| 21. I certify that XXX (this hospital) attended the deceased from 4/14/62 , 19 62 , to 4/23/62 , 19 62 , and that death occurred at 12.10 from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Seymour Goldgraben M.D. | | | 22b. DATE SIGNED 4/23/62 | | |
| 22c. PHYSICIAN'S NAME (Type) Seymour Goldgraben, MD. | | | 22d. ADDRESS VAH., Perry Point, Md. | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) Buried | | 23b. DATE THEREOF 4/26/62 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Erin Catholic | |
| 23d. LOCATION (City, town or county) Havre de Grace, Md. | | 23e. (State) Md. | | 23f. (Country) USA | |
| 24. FUNERAL DIRECTOR'S SIGNATURE William R. Howard ADDRESS Harford County, Md. | | | 25a. REC'D BY REGISTRAR MAY 3 '62 | | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Hays | | | 25c. DATE MAY 3 '62 | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04454
CERTIFICATE OF DEATH
04452

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|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville, Rural c. LENGTH OF STAY IN 1b 45 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt 222 | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville, Rural d. STREET ADDRESS Rt. 222 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lida Middle A. Last Michael | | 4. DATE OF DEATH Month April Day 9 Year 1962 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH April 1, 1880 |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (County & State, or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Nathan Morris | |
| 14. MOTHER'S MAIDEN NAME Sarah Billingsley | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | |
| 16. SOCIAL SECURITY NO. 219-36-0226 | | 17. INFORMANT Mildred E. Koontz, Perryville, Md. Rural | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 DUE TO (b) 2 (c) 2 | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from Nov-10, 1961 to April 9, 1962 , that (I) (we) last saw the deceased alive on April 9, 1962 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. | |
| 22a. SIGNATURE Clarence I. Benson M.D. | | 22b. DATE SIGNED April 10, 1962 | |
| 22c. PHYSICIAN'S NAME (Type) Clarence I. Benson | | 22d. ADDRESS Port Deposit, Md. | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) Burial | | 23b. DATE THEREOF 4-12-1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery | | 23d. LOCATION (City, town or county) (State) Perryville, Md. Rural | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md | | 25a. REC'D BY REGISTRAR APR 13 '62 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas | | 25c. DATE SIGNED | |

04432

04432

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04453
CERTIFICATE OF DEATH
04453

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| 1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 9 mo. 20 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5415 Knell Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOHN LAWRENCE OBITZ | | 4. DATE OF DEATH Month Day Year April 19 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-27-76 |
| 9. AGE (In years last birthday) 85 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | 11. BIRTHPLACE (County & State, or foreign country) Maryland |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Obitz (deceased) | | 14. MOTHER'S MAIDEN NAME Gracey (deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 215-18-7245 | |
| 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Ventricular arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis generalized severe | | INTERVAL BETWEEN ONSET AND DEATH 2-5 min. Years Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XXXXXX attended the deceased from June 30 , 19 61 to April 19 , 19 62 and that death occurred at 7:30pm from the causes and on the date stated above. | | | |
| 22a. SIGNATURE A.L. Mooney | | 22b. DATE 4-20-62 | |
| 22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md. | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 4/21/62 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY National | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Birmingham & Son | | 25a. REC'D BY REGISTRAR APR 23 '62 | |
| ADDRESS Havre de Grace, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Frank | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04456

CERTIFICATE OF DEATH

04454

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| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 75 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington - D.C. d. STREET ADDRESS 1106 - 8th Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle L. Last PINKNEY | | 4. DATE OF DEATH Month 4 Day 24 Year 19 62 | | 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-11-91 | | 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months 70 Days | | IF UNDER 24 HRS. Hours 70 Min. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Trucking | | | | 11. BIRTHPLACE (County & State, or foreign country) Aiken, S.C. | | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | | | | | | | | | |
| 13. FATHER'S NAME William Pinkney (deceased) | | | | | | | | 14. MOTHER'S MAIDEN NAME Judy Brown (deceased) | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | | | | | | | 16. SOCIAL SECURITY NO. Unk. | | | | | | | | 17. INFORMANT Address VA Hospital Records - Perry Point, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia bilateral 288X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Pyelonephritis acute bilateral DUE TO unknown (c) Systemic gout DUE TO unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 48-72 hrs. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 62 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that DOCTOR A. L. MOONEY attended the deceased from 2-8-62 , 19 62 , to 4-24-62 , 19 62 , and that death occurred 12:05 a.m. from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE A. L. Mooney M.D. 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. | | | | | | | | | | | | | | | | 22b. DATE SIGNED 4-24-62 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | | 23b. DATE THEREOF 5-30-62 | | | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | | | 23d. LOCATION (City, town or county) (State) Arlington, Va. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. H. Bacon ADDRESS 1722 7th St. NW | | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE APR 27 '62 | | 25b. REGISTRAR'S SIGNATURE Arthur L. Harris | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR AFTER DEATH. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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"Tab 55"

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**FOR STATE
HEALTH DEPT.**

play is necessary,
and director. Page
for your files.
Board of Health,

TO 1. JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

| | | | |
|--|---|--|---|
| 1. PLACE OF BIRTH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | | b. COUNTY Cecil | |
| c. LENGTH OF STAY IN 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Front St. | | d. STREET ADDRESS Front | |
| 3. NAME OF DECEASED (Type or print) Ernest Preston | | 4. DATE OF DEATH 4 29 19 62 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-25-1891 |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY all kinds of work | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Isaac Preston | | 14. MOTHER'S MAIDEN NAME Helena Woodrow | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes W.W.I | | 16. SOCIAL SECURITY NO. 083-05-1789 | |
| 17. INFORMANT Mrs. Ernest Preston, Perryville, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion and Diabetes 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1) MIN. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE R.C. Dodson | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-29-62 Rising Sun, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-2-1962 | 22c. NAME OF CEMETERY OR CREMATORY Principio Cemetery | 22d. LOCATION (City, town, or country) (State) Principio Furnace, Md. |
| 23. FUNERAL DIRECTOR Vera Patterson | | 24a. REC'D BY REGISTRAR MAY 2 '62 | |
| ADDRESS Perryville, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

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James Preston

03-02-1909 Mrs. Ernest Preston, Perryville, Md.

For W. J.

John.

Coronary Occlusion and Diabetes

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Blaine Sw., Md.

R. J. Boston

Ernest Preston - Perryville, Md.

Ernest Preston

Perryville, Md.

Perryville, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04458

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04456

Items 18 & 21, 1962 - 0-212 5/7/62. c.c.

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street and no.) Union Hospital | | d. STREET ADDRESS 118 Milburn Street | | | |
| 3. NAME OF DECEASED (Type or print) MONICA | | First PURDIE | | 4. DATE OF DEATH Month April Day 16, Year 1962 | |
| 5. SEX Female | | 6. COLOR OR RACE Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH July 6, 1961 | | 9. AGE (In years last birthday) yrs. 9 | | IF UNDER 1 YEAR Months 9 Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Thomas Purdie | | | |
| 14. MOTHER'S MAIDEN NAME Elizabeth Givens | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | | |
| 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Thomas Purdie | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purulent meningitis 340.0 DUE TO Hemophilus influenzae. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 4/16/62 | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Apr. 17, 1962 | | 22c. NAME OF CEMETERY OR CREMATORY Providence Meth. Cem. | |
| 22d. LOCATION (City, town, or country) Elkton, Md. | | 22e. REC'D BY REGISTRAR | | 22f. REGISTRAR'S SIGNATURE Arthur L. Hume | |
| 23. FUNERAL DIRECTOR Ralph E. Hicks, Elkton, Md. | | 23a. ADDRESS | | 23b. DATE APR 19 1962 | |

04158

04158



JULY 5, 1961

Thomson Radio

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TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04459

CERTIFICATE OF DEATH

Reg. Dist. No. 04457

| | | | |
|--|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | d. STREET ADDRESS Blue Ball Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First FRED Middle RUSSELL Last RABY | | 4. DATE OF DEATH Month April Day 18, Year 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 25, 1895 |
| 9. AGE (In years last birthday) 66 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner | | 10b. KIND OF BUSINESS OR INDUSTRY Mining | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James R. Raby | | 14. MOTHER'S MAIDEN NAME Ruemma Roland | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1 | | 16. SOCIAL SECURITY NO. 233-07-6591A | |
| 17. INFORMANT Eliaz Blankenship | | Address Elkton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42010 DUE TO Anterior-chorotic Heart Disease with Cardiac standstill Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Summed | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (1) Advanced pulmonary tuberculosis 002.1 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-22, 1962, to 4-18, 1962, that I lost saw the deceased alive on 4-17, 1962, and that death occurred at 4:11 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE T. Johnson | | ADDRESS (Street, city or town, state) 123 S. Sengerly Ave | |
| PHYSICIAN'S NAME (Type) T. Johnson | | DATE SIGNED 4-19-62 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 21, 1962 | |
| 22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery | | 22d. LOCATION (City, town, or county) (State) Elkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald H. Du | | 24a. REC'D BY REGISTRAR DATE APR 23 '62 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Krawe | |

01-123

CONFIDENTIAL - NO DISSEM

01-123

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be marked "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|--|--|---------------------------|--|---|--|-------------------------------|--|---|---------------------|--|--|
| Item 20 Film 311 4-24-62 | | | | | | | | | | | |
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 04460 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04458 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY CECIL MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 40 Principio Creek c. LENGTH OF STAY IN 1b - d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton d. STREET ADDRESS 213 Landing Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES RAYMOND RAMSEY | | | | | 4. DATE OF DEATH Month Day Year 4 10 1962 | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-29-1902 | | 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER Maryland State Roads | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME William T. Ramsey | | | | | 14. MOTHER'S MAIDEN NAME Bertha Reynolds | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. 218-16-1421 | | 17. INFORMANT William Thomas Ramsey Rising Sun 2, Md Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816x Compound fracture of frontal bone with loss of brain tissue DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH instant | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was hit by truck while riding in pick up truck | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour am 4 10 19 62 p.m. | | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 | | 20f. (City or town) Principio Creek, Cecil, Md | | (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4-10-1962 Address (Street, city, town, or county) | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) R.C. Dodson Rising Sun, Md | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 22b. DATE THEREOF 4-13-1962 | | 22c. NAME OF CEMETERY OR CREMATORY Rosebank | | | 22d. LOCATION (City, town, or country) Calvert Cecil Co., Md | | | |
| 23. FUNERAL DIRECTOR Joseph R. Grant North East, Maryland | | | | | 24a. REC'D BY REGISTRAR DATE APR 13 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hanna | | | | |

01158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01158

THE JURY

DATE

TIME

PLACE

LOCATION

NO.

DATE

DECEASED

AGE

SEX

RACE

RELIGION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

POST-MORTEM

TESTIMONY

19-10-1911

Longitudinal fracture of femur bone with loss of brain substance

Medical Examiner, Cecil

House No.

Station No.

Station No.

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FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04461 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04459

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|--|--------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Alice B. Smith | | | 4. DATE OF DEATH Month 4 Day 9 Year 19 62 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-11-1894 | | 9. AGE (In years last birthday) 67 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 13. FATHER'S NAME Frank Behnatt | | 14. MOTHER'S MAIDEN NAME Rosa Buskirk | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Hospital Records | |
| | | | | Address Elkton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 42011 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 min. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE R.C. Dodson | | CHIEF MEDICAL EXAMINER | | DATE SIGNED 4-20-62 | |
| EXAMINER'S NAME (Type) R.C. Dodson | | ASSISTANT MEDICAL EXAMINER | | | |
| | | DEPUTY MEDICAL EXAMINER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF April 12, 1962 | | 22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery | |
| | | | | 22d. LOCATION (City, town, or country) Cecilton, Cecil Co; Md. | |
| 23. FUNERAL DIRECTOR Edward Fellows, Mellington, Md. | | 24a. REC'D BY REGISTRAR DATE APR 17 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

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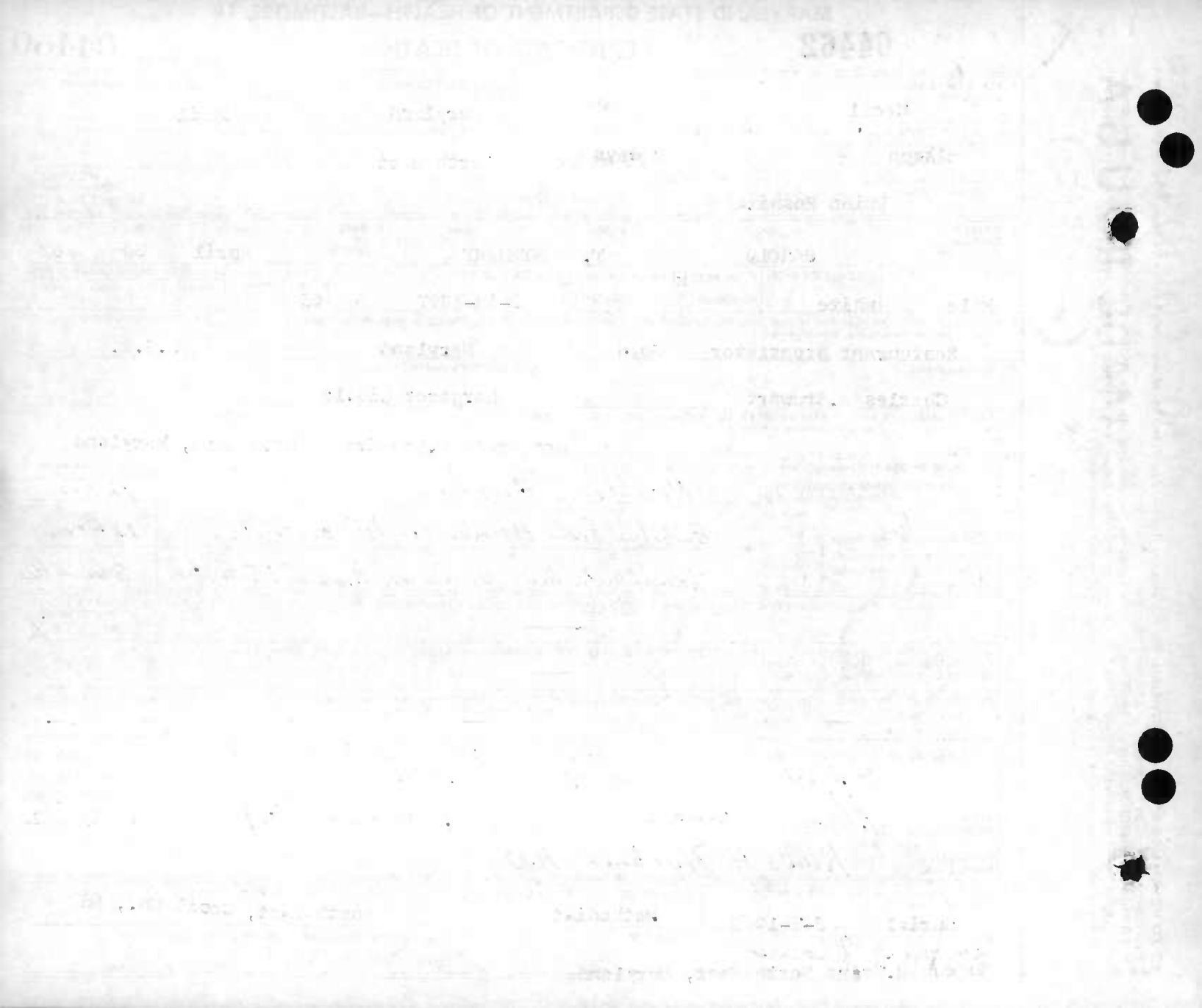
CERTIFICATE OF DEATH

Reg. Dist. No.

04160

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|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton East | | | | c. LENGTH OF STAY IN 1b 2 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First HAROLD Middle T. Last STEWART | | | | 4. DATE OF DEATH Month April Day 30 Year 1962 | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-10-1897 | |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant proprietor | | | | 10b. KIND OF BUSINESS OR INDUSTRY Food | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Charles A. Stewart | | | | 14. MOTHER'S MAIDEN NAME Margaret Biddle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. INFORMANT Address Mrs Freda P. Stewart North East, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42010 Mesenteric Thrombosis DUE TO (b) Embolus From thrombus in left ventricle DUE TO (c) Arteriosclerotic Heart Disease and Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. 12 Hrs. 8 months | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Aug 1961 to 30 April 1962 that I last saw the deceased olive on 30 April 1962 and that death occurred at 10:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Klaus H. Huebner M.D. | | | | ADDRESS (Street, city or town, state) North East, Md DATE SIGNED 4/30/62 | | | |
| PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-3-1962 | | 22c. NAME OF CEMETERY OR CREMATORY Methodist | | 22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland | | | | 24a. REC'D BY REGISTRAR MAY 4 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas | |

TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. The registrar may be assisted by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04463
CERTIFICATE OF DEATH

04461

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|---|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN b 2 mo. 18 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Delaware b. COUNTY Wilmington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 900 Marsh Road d. STREET ADDRESS April 30 19 62 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) HARRY J. STIDHAM | | 4. DATE OF DEATH Month Day Year April 30 19 62 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-29-79 |
| 9. AGE (In years last birthday) 82 | | 10. IF UNDER 1 YEAR Months Days 10 29 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 12. BIRTHPLACE (County & State, or foreign country) Delaware | |
| 13. FATHER'S NAME Franklin Stidham (deceased) | | 14. CITIZEN OF WHAT COUNTRY USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 221-07-4377 | |
| 17. INFORMANT S.A.W. | | Address Hospital Records, VAH, Perry Point, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular arrhythmia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0 DUE TO (b) Aortic valve calcification, severe. DUE TO (c) Arteriosclerotic Heart Disease. | | INTERVAL BETWEEN ONSET AND DEATH 1 to 3 min Unknown Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. VA 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XXXXXX attended the deceased from February 12 62 to April 30 62 , that (1) (two) last XXXXXX and that death occurred at 10:45am from the causes and on the date stated above. | | 22a. SIGNATURE a.l. mooney M.D. 22b. ADDRESS A. L. MOONEY Asst. Clinical Pathologist, VAH, Perry Point, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL Removal | | 23b. DATE THEREOF 4-30-62 | |
| 23c. NAME OF CEMETERY OR CREMATORY Riverview | | 23d. LOCATION (City, town or county) (State) Wilmington, Delaware | |
| 24. FUNERAL DIRECTOR'S SIGNATURE JONES FUNERAL HOME | | 25a. REC'D BY REGISTRAR MAY 4 '62 | |
| ADDRESS Claymont, Delaware | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

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TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completed by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04464

04462

| | | | |
|--|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital | | d. STREET ADDRESS 710 Bridge Street | |
| 3. NAME OF DECEASED (Type or print) WILLIAM PENN TITTER | | 4. DATE OF DEATH April 4, 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 25, 1877 |
| 9. AGE (In years last birthday) 85 yrs. | | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Co. | | 10b. KIND OF BUSINESS OR INDUSTRY Telephone | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Kirk Titter | | 14. MOTHER'S MAIDEN NAME Martha Mullin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-05-0694 | |
| 17. INFORMANT Mrs. Felicita S. Tatman | | Address Chesapeake City Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute cardiovascular accident - probably cerebral thrombosis DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | INTERVAL BETWEEN ONSET AND DEATH 11 days unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Mar. 23 1962 to Apr. 4 1962, that (I) (we) last saw the deceased alive on Apr. 3 1962, and that death occurred at 12:30 am, from the causes and on the date stated above. | | 22a. SIGNATURE S. Ralph Andrews, Jr., M.D. M.D. | |
| 22b. DATE 4/4/62 | | 22c. PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | |
| 22d. ADDRESS 233 E. Main St., Elkton, Maryland | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF April 7, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery | | 23d. LOCATION (City, town or county) (State) Elkton, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald M. Pippin | | 25a. REC'D BY REGISTRAR APR 9 '62 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

04465

CERTIFICATE OF DEATH

Reg. Dist. No.

05722

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|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Childs | | | | c. LENGTH OF STAY IN 1b 17 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS Childs | | | |
| 3. NAME OF DECEASED (Type or print) First Frank Middle Walker Last | | | | 4. DATE OF DEATH Month April Day 30 Year 19 62 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 15, 1893 | |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME ----- | | | | 14. MOTHER'S MAIDEN NAME ----- | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 216-14-3628A INFORMANT Address Mrs. Frank Walker, Childs, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease with 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Jan , 1960 , to April 30, 1962 that I last saw the deceased alive on April 30, 1962 and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 123 Singlerly Ave DATE SIGNED 5-4-62 ACTUAL SIGNATURE Tillman D. Johnson M.D. PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D. Elkton, Md | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/4/62 | | 22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery | | 22d. LOCATION (City, town, or county) (State) Elkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Elkton, Md. | | | | 24a. REC'D BY REGISTRAR MAY 10 '62 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kline | |

10753

DEPARTMENT OF COMMERCE

10753

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF MARITIME SERVICE
WASHINGTON, D. C.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04466
CERTIFICATE OF DEATH
04463

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Elkton d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton, d. STREET ADDRESS Route 5 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Elmer G. Wertz | | 4. DATE OF DEATH Month Day Year April 5 1962 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 15, 1892 |
| 9. AGE (In years last birthday) 69 yrs. | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - | | 10b. KIND OF BUSINESS OR INDUSTRY paper maker | |
| 11. BIRTHPLACE (County & State, or foreign country) Reading, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Wellington Wertz | | 14. MOTHER'S MAIDEN NAME Elizabeth Repard | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W W I | | 16. SOCIAL SECURITY NO. 217-05-3861 | |
| 17. INFORMANT Mrs. Hazel A. Wertz, Elkton, Md. | | Address Route 5 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac rhythm disorder with Cardiac standstill DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Heart Disease, decompensated with atrial fibrillation DUE TO (c) None | | INTERVAL BETWEEN ONSET AND DEATH Immed. years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 26, 1960 to 4-5, 1962 , that (I) (we) last saw the deceased alive on 3-29, 1962 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Tillman D. Johnson M.D. | | 22b. DATE SIGNED 4-8-62 | |
| 22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson | | 22d. ADDRESS 123 Sincerly Ave., Elkton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF April 9, 1962 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery | | 23d. LOCATION (City, town or county) (State) Cecil County, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks | | 25a. REC'D BY REGISTRAR APR 19 '62 | |
| ADDRESS Elkton, Maryland | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hanna | |

1955

CERTIFICATE OF MARRIAGE

1955

Geoff

Maryland

Geoff

Alison

Alison

Union Hospital

House 3

Almer

Wente

Male

White

May 15, 1952

Retired

paper maker

Reading, Pennsylvania

Wellington Wente

Elizabeth Wente

Yes

W W I

217-05-2881

Mrs. Hazel A. Wente, Elkhart, IN

House 3

April 9, 1955 Cherry Hill Cemetery, Cecil County, Maryland

Elkhart, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director may be required to attend the deceased and attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

04467

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film G311 4/26/62 mh
CERTIFICATE OF DEATH

Reg. Dist. No. 04464

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RISING SUN (Rural)</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>YATES</u> | | 4. DATE OF DEATH Month <u>APRIL</u> Day <u>18</u> Year <u>1962</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1895 SEPT. 15, 1895</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JAMES SLATE</u> | | 14. MOTHER'S MAIDEN NAME <u>HANNA JAMES</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>220-22-6752</u> | |
| 17. INFORMANT <u> </u> | | 18. ADDRESS <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma, gall bladder</u> 155 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>62</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>4/10</u> , 19 <u>62</u> , to <u>4/18</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>62</u> , and that death occurred at <u>1304</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John A. Fischer</u> | | ADDRESS (Street, city or town, state) <u>162 W MAIN ST. ELKTON, MD</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN A FISCHER</u> | | DATE SIGNED <u>4/19/62</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>4/21/1962</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>HOPEWELL CEMETARY</u> | | 22d. LOCATION (City, town, or county) (State) <u>PORT DEPOSIT MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed</u> | | ADDRESS <u>Rising Sun, Md</u> | |
| 24a. REC'D BY REGISTRAR <u> </u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |

1-1-19

1-1-19

1-1-19